



**TESTIMONY**

Delivered by Tracy Wodatch, Vice President of Clinical and Regulatory Services  
The Connecticut Association for Healthcare at Home

Before the Public Health Committee

**March 17, 2014**

**To OPPOSE Raised Bill No. 5326:  
An Act Concerning Compassionate Aid in Dying for Terminally Ill Patients**

Senator Gerratana, Representative Johnson and members of the Public Health Committee. My name is Tracy Wodatch, Vice President of Clinical and Regulatory Services at the Connecticut Association for Healthcare at Home. I am also an RN with 30 years experience in home health, hospice, long term and acute care.

The Association represents 60 Connecticut DPH licensed/Medicare certified home health and hospice agencies that foster cost-effective, person-centered healthcare in the setting people prefer most – their own home.

The CT Association for Healthcare at Home is the united voice for 26 of the 27 hospice and palliative care providers in Connecticut. Our membership includes uniquely and highly qualified individuals and provider organizations with perspectives and expertise drawn from direct care experiences with those facing terminal illness.

**The CT Association for Healthcare at Home opposes Bill No. 5326  
An Act Concerning Compassionate Aid in Dying for Terminally Ill Patients**

On behalf of the Association and its members, I testified before your committee last week in support of SB 413 AAC a MOLST pilot which emphasizes the importance of best practice for hospice and palliative care services, consumer education, informed choice, conversations with the primary care provider regarding available services, goals of care, and quality end-of-life care. Physician-Assisted Suicide is not an option that promotes quality end-of-life care.

Connecticut currently ranks last or 51<sup>st</sup> in the country in hospice length of stay which translates into “last minute hospice or end-of-life care.” The provider continuum is not doing enough to promote hospice and palliative care services resulting in poorly informed consumers regarding their end-of-life options. Perhaps this is why some feel a bill on Physician-Assisted Suicide is needed as they are not fully informed of the wide array of expert end-of-life services and supports available to them.



This bill puts tremendous burdens on the physicians who may be feeling significant pressure from their patients who may not know the many options available to them. So...my question to the physician population who may face the request from a patient for Physician-Assisted Suicide would be, “Are you as a physician fully informed of the value of hospice and palliative care? Have you done your research to ensure your patient is aware of all the options available that would be able to relieve their pain and suffering yet allow them to continue to experience quality of life until a peaceful death naturally occurs?” I encourage physicians to be fully informed, to do their research, to visit a hospice agency and a hospice patient—this knowledge should, in turn, be shared with their patients.

Instead of considering legalizing Physician-Assisted Suicide, let’s instead focus our efforts on the essence of hospice care which is to allow patients to make the most of their remaining time. Hospice values people’s lives until their natural end, making their death a true “death with dignity.” Our Association and its members affirm and promote the importance and ongoing need for education and access to hospice and palliative care for terminally ill people and their families.

**Here are some of the things Hospice and Palliative Care providers can do:**

- Offer expert, compassionate relief of pain and suffering at end of life enhancing the quality of both living and dying.
- Strive to help patients and families deal with important physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes and fears.
- Promote opportunities for meaningful experiences, and personal and spiritual growth so patients may live life to the fullest and die with dignity.
- Assist patients and families cope with loss and grief through best-practice bereavement support and
- Support the patient’s right to participate in all decisions regarding their care, treatment and services based on knowledge and access to all forms of treatment that have been shown to enhance quality of life and reduce suffering.

The CT Association for Healthcare at Home is committed to the hospice philosophy cherishing life until its natural end while reinforcing dignity, quality and comfort. Our Association and its 26 hospice providers afford the highest regard for person-centered choice and self-determination. We look forward to participating in and guiding the ongoing dialogue and debate to continuously improve upon and promote comfort and dignity in life closure. ***We do NOT support the legalization of physician-assisted suicide.***



Despite our opposition to this bill, we have grave concern for language within the bill itself. We recognize the attention that this bill has assumed in your committee and in the public. As you continue to debate this issue, we ask that you consider several specific concerns not addressed currently within the language of the bill.

- The definition of “Palliative Care” on page 2 of 11 is inaccurate and should read “Palliative Care means health care centered on a **seriously** (not terminally) ill patient and such patient’s family...”
- Hospice care is not defined and should be. There are many references to “palliative care” within the language but none to hospice. At the top of p6 of 11 under (3)(E), it should state “the feasible alternatives and health care treatment options including but not limited to **hospice and palliative care.**”
- Determining terminal prognosis is not an exact science as many people outlive a 6 month prognosis and go on to live several months or years beyond their initial prognosis. However, there are accepted tools/scales used to predict prognosis. We strongly recommend that these tools (e.g, Karnofsky or FAST) be mandated as part of determining prognosis.
- To avoid subjectivity in determining the competency (both cognitive and for s/sx’s of depression) of the patient requesting a physician to assist in his/her suicide, we strongly recommend that the physicians determining competency must use a standardized validated tool for both cognitive and depression assessment.
  - Depression is one of the most underdiagnosed illnesses among the elderly and seriously ill.
- P 7 of 11, the cause of the death on the death certificate should not be the underlying disease. The cause of death should be “barbiturate overdose or toxicity.” Given the inexact science of determining a projected prognosis of a disease, a natural death may be for a number of reasons other than the underlying disease itself.
- P9 of 11 section 16 (a), there’s reference to mercy killing and euthanasia which are not defined and should be.
- Finally, any person requesting “Compassionate Aid in Dying” should first be required to have a Hospice and Palliative Care consult.

Thank you for considering our association’s testimony. If you have any further questions, please contact me directly at [Wodatch@cthealthcareathome.org](mailto:Wodatch@cthealthcareathome.org) or 203-774-4940.